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ABSTRACT

Community Based Consultation, a consultation/education model appropriate for use in CMHC's and mental health departments is described. The model is being implemented by a Community Services Team of a rural mental health department. Appropriate strategies, a conceptualization of the community along power dimensions, a decision-making structure for where in the community to intervene, entry strategies, evaluation results and issues are presented. (Author)

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Community Based Consultation

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Community-Based Consultation is a model of consultation designed especially to meet mental health needs of people from diverse areas of a community. It provides a problem solving structure for planned and systematic intervention with special regard for politically relevant factors of the community. This system of consultation, as compared with other models of consultation, views the community, rather than an individual or an organization, as the client. Consultation occurs with all levels of trained persons, rather than professionals only and engages informal and formal organizational structure; and can aid in the development of organizational structure where none exists.

When the community is viewed as a system it is clear that some people and/or organizations have more influence than others. In Figure 1 a community has been conceptualized as concentric circles. The more powerful have been placed in the center. These people have high frequency or high status contact with others, and are likely information sources for the community. This model of the community sees persons in the peripheral circle as more isolated and over-represented on treatment lists at mental health centers.

Intervention is necessary at as many levels or circles of the system as possible. To intervene near the periphery is important because this population is the most demanding of traditional direct services. If the periphery were not addressed, then the mental health center would be seen as not responsive to community "pain" and be overwhelmed with a waiting list.

Intervening at the center with the more influential is important because these persons or organizations are able to use themselves to be supportive of positive mental health skills as they carry out their everyday functions. To neglect the influential would be to overlook the strength of the community in supporting its own mental health growth. Ignoring the power bases of the community would also increase the risk of being seen as not useful to community members with consequent loss of funding. Though there are advantages in terms

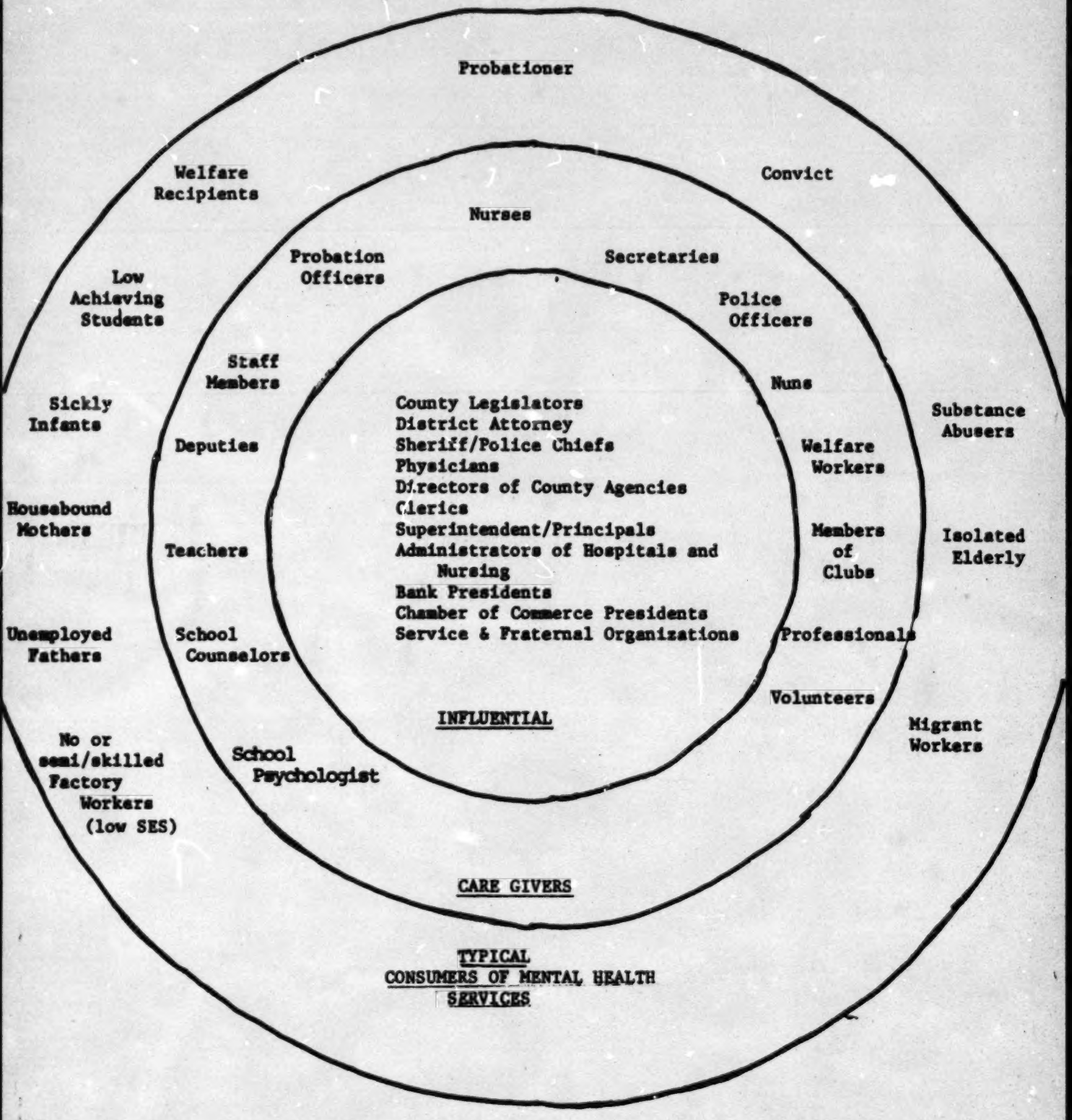

Figure 1 Concentric Circle Conceptualization of a Community

of efficiency with targeting interventions to central persons, who are better educated and fewer in number than the peripheral population, there are also some drawbacks. For example, since the communication lines between the center and periphery are often indirect, informal and happenstance, there can be a long lag time in spreading information through these channels. In addition, there is the possibility of a "watering down" effect occuring on interventions as they spread throughout the community and finally reach the peripheral person most in need of, or at least, most demanding of aid.

Many different types of interventions can be used in the community, these include:

1) Facilitating the development of organizations within the community, e.g., a self help coordinating committee, self help groups, family care homes, community residences.

2) Increasing the capacity of organizations to provide services which are mental health oriented, e.g., administrative consultation, inservice training to staff, publicizing community organizations, assisting organizations in writing grants.

3) Training professionals and para-professionals in counseling skills, e.g., at local hospitals, schools, nursing homes, community workshops and presentations.

4) Consulting from the client and consultee-centered frame of reference, e.g., consulting with school counselors about different ideas in working with a particular child.

5) Educating the community, e.g., self help groups, presentations to community groups, providing self education or self change educational packets.

The preferred intervention strategy is to help another community group provide a mental health service. This strategy is important because it not only allows mental health involvement in more activities, but also develops a more self-sufficient community and fosters greater interdependency in the community. For example, the Mental Health Department was receiving many referrals

from probation officers to provide mental health counseling to their probationers. We began consulting with the probation officers to help them deal with the mental health needs of their probationers more effectively. Before our intervention, Probation referred 34 persons between January and June of 1977. After our intervention, there were 10 persons referred between January and June of 1978. Total number of probationers remained about the same during those two periods.

The strategy of Community-Based Consultation stresses not supplanting services provided in the community independent of the Mental Health Department. This point seems to be common sense yet is easily overlooked. For example, our department provides 24 hour emergency service to the county. Before our emergency service began two 24 hour telephone counseling services serving the county were already operating. In forming our emergency service we met with the telephone counseling services to let them know that in order to avoid undermining their service we were publicizing our service only to the area primary care givers. We have given our number to the telephone counseling services, to hospital emergency rooms, the law enforcement agents, the physicians, clergy and so on. In doing so, we acknowledge our interest in being actively involved with the most severe mental health problems that people experience, but not in doing away with the community's own active pursuit of providing mental health services.

At times the decision is made that it is necessary to sponsor or form organizations when there are no existing organizations. Organizations are formed based on the kinds of problems that people who are requesting services exhibit. For example, upon receiving many requests for services from families that need relationship or parenting skills, we began to train and supervise clergy, school professionals, and area graduate students in family counseling. The goal is to help these professionals feel more comfortable dealing with the entire family. Also there is provision of parenting and communication skills modules which are educational and practice oriented to peripheral community

members. Users of these modules sometimes develop into self help groups.

Another example of initiating an organization is the formation of self help groups. Because of the low concentration of people in any one area of our rural community, we formed non-traditional self help groups. That is, instead of being problem-centered groups, the self help groups are problem-solving groups. This enables people with a variety of problems to join together in the same group to solve their problems.

Community-Based Consultation is termed systematic because conscious proactive choices are made of where to intervene in the community rather than to intervene in a reactive, haphazard fashion. The decision of where to intervene in the community is based upon the characteristics of the various community organizations. Decisions to intervene are based on:

1) which organizations overlap most nearly with the Mental Health Department in terms of the population being served;
2) ease of developing a consultation relationship, e.g., attitude toward the Mental Health Department, organizations experiencing an acute need;
3) capacity to serve mental health needs (preventative and rehabilitative), e.g., type of usual interaction with clients;
4) number of persons served by the organization.

These criteria help decide where intervention can impact with the largest number of people at the least cost. For example, we have created consultative linkages with the Public Health Nurses, the two community hospitals, the five facilities for the elderly, the county physicians, the Department of Social Services (particularly protective services for adults and for children), the Office of the Aging, Retired Senior Volunteer Program, Alcoholics Anonymous, the Probation Department, the County Jail, the County Sheriff's Department, local police departments, schools, the Board of Cooperative Education Services, the two telephone counseling services, local clergy, Cooperative Extension, Youth Bureau, YW and YMCA, and the three colleges in the county.

The interventions with these agencies would be impossible if the important step of entry into the community were not accomplished. Often information that would be beneficial to a community is not communicated or implemented because the information is not strategically placed. Strategically forming relationships or accomplishing entry requires having both interpersonal skills and something to offer the person or agency. We have used crisis intervention, inservice training, client consultation and stressing similar needs as tactics for forming working relationships. For example, aiding physicians by providing crisis intervention service to their patients has enabled us to form a mutually supportive relationship. In reciprocity, with consultation from our psychiatrist, the physicians will prescribe medications to our clients, thereby easing our psychiatric work load.

An example of stressing similar needs is our entry into the Office of the Aging. We approached the Office of the Aging by emphasizing that we are working on many of the same problems which face the elderly. Perhaps, we suggested, our combined efforts would better serve the elderly. We are now working on a geriatric day center and a transportation network to serve their clients and ours.

The evaluation of success for Community-Based Consultation is difficult and incomplete at present. Depending on one's perspective, differing aspects would be of interest.

A community based model has multiple facets and levels amenable for evaluation. An incomplete list of important aspects to consider include the following:

a) impact on outpatient services of the Mental Health Department; b) number of caregiving agencies consultatively linked with the team; c) position (re: the concentric circle configuration) in the community of consultative relationships; d) impact on the care-giving functions of other agencies; e) diffusion across the non-professional community of care-giving responsibilities;

and f) number of new organizations established due to the efforts of the team.

Though this list is surely just scratching the surface, preliminary data are available on the above points.

What is the impact on outpatient services? The Community-Based Consultation effort has altered the incoming referral pattern in that some agencies are handling service needs themselves with consultation. In addition, the clients being served by outpatient are types exhibiting more severe disturbance than previously. As Community-Based Consultation raises the profile of the Mental Health Department the Outpatient Services receives more requests for services. To deal with this demand for more services Outpatient Services clearly defines the priority of which people to serve. Community-Based Consultation increases the alternative services for those persons with lower priority and less severe problems.

People who have traditionally been seen on an inpatient basis are being seen on an outpatient basis and persons who were traditionally seen on an outpatient basis are seen by community providers or by the crisis intervention team. Community providers include self-help groups, people in family counseling course, probation officers, clergy, school personnel, etc....

Another indication is the number of Family Care Homes now as compared to before the active community involvement, one then, to four now. Also a grant for community residences will soon be received.

How has the community accepted the idea of Community-Based Consultation? We have been asked to be on many advisory boards in the community. We have been asked back to every consultation contact.

How powerful or central are the people with whom we have been able to form relationships within the county? We have had appropriate requests for community service from 3 of the 19 in the county governing body. Seven of the 17 county physicians call us for consultation. The county District Attorney calls us and works with us on crisis and conditional discharges of arrested persons with psychological problems.

An Interagency Coordinating Committee for Health Services has been formed to increase cooperation. It is composed of the department heads of the Mental Health Department, Social Services, Planning, Probation, Public Health Nursing, Office of the Aging, and a representative of the State Psychiatric Center.

Though still evolving as a model for consultative action in the community, Community-Based Consultation has proved an effective, conceptual vehicle for our Mental Health Community Services Team. It has provided a structure for proactive decision-making in regard to the deployment of our limited person resources. It has been the coneptual springboard for the kind of mental health services to offer to our community. It has helped us predict the stresses we would feel in our own department, for example, direct services to clients and plan to deal constructively with those expressed need rather than become involved in energy draining intra-departmental struggles.

Though an oft expressed lament of the practitioner is his/her distance from and low regard for theoretical formulations, our experience point to the value of the scientist/practitioner orientation. A careful study of what others have said and done in community has enabled us to formulate a "theory-n-action" that is the cornerstone of our mental health facilitating endeavors for our community. It may, of course, not be a unique approach as it is surely based on earlier conceptualizations and more current mandates. But it is actually staffed by people on the applied edge of community psychology.